STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING _____ B. WING _____	C 01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	**325 W NORTHWOOD DR SULLIVAN, IN 47882**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00102305. Complaint IN00102305 - Unsubstantiated due to lack of evidence. Survey Dates: January 23, 24, 25, 26, 27 & 30, 2012 Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010 Survey Team: Mary Weyls RN, TC (January 23, 24, 25, & 30, 2012) Laura Brashear RN (January 23, 24, 25, 26, & 30, 2012) Teresa Buske RN Debra Skinner RN Census Bed Type: SNF/NF: 41 NCC: 1 Total: 42 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 4 Total 42 Stage 2 Sample: 31 Breckenridge Health & Rehabilitation was found to be in compliance with 42 CFR Part 483	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING _____ B. WING _____	C 01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey and the Investigation of Complaint IN00102305. Quality review 2/01/12 by Suzanne Williams, RN	F 000		